Cigna Medicare Supplement Insurance
Cigna Health and Life Insurance Company

APPLICATION BOOKLET FOR CALIFORNIA

This packet contains all required forms for application submission. Please complete each form according to the instructions on each page.

- Application
- Guaranteed Acceptance Guide
- Electronic funds transfer agreement
- HIPAA notices
- Replacement notice
- Anti-Discrimination disclosure

Note: All Applications outside of OE/GI require a Phone Verification (PV) – Reduce delays and make the PV call at the point-of-sale. **Call our PV Hotline at 866.825.4822 from 7 a.m. to 7 p.m. Central Time.**

Together, all the way.®

Cigna®

APPLICATION for MEDICARE SUPPLEMENT INSURANCE

Cigna Health and Life Insurance Company
PO Box 5725, Scranton, PA 18505-5725 • Customer Service 866-459-4272 • www.Cigna.com
Phone Verification (PV) Hotline 866-825-4822 • FaxApp Submission 877-704-8186

Application is for: ☐ New business ☐ Reinstatement Phone verification case #(s) _____

› If you complete this application with another Applicant, you are consenting to the other Applicant viewing the protected health information that you provided on this application.

› If only one Applicant, complete Applicant A questions.

A. Personal information

Applicant A

Name *(First MI Last)* | **Age** | **Date of birth** *(MM/DD/YYYY)* | **Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* | **Phone** ( )

Mailing address *(if different from resident address)* | **Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically.*

Applicant B

Name *(First MI Last)* | **Age** | **Date of birth** *(MM/DD/YYYY)* | **Gender** ☐ Male ☐ Female

Resident address *(Street, City, State ZIP)* – OR check box ❑ if same as Applicant A | **Phone** ( )

Mailing address *(if different from resident address)* | **Social Security no.** *(XXX-XX-XXXX)*

Email address *(optional) By providing your email address, you agree to receive marketing content electronically.*

Premium discount (see Outline of Coverage for details)

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
1. a. Do you live with someone 18 years or older (6% "Household Premium" discount)?	☐	☐	☐	☐
b. If YES, do they have a Medicare Supplement policy with Cigna Health and Life Insurance Company or an affiliate of Cigna Health and Life Insurance Company (11% "Multi-Insured" premium discount)?	☐	☐	☐	☐

2. If you answered YES to 1b, please provide member information if other than Applicant A or Applicant B.

Name *(First MI Last)* | **Social Security no.** *(XXX-XX-XXXX)*

B. Please provide your Medicare information *(as shown on your Medicare card)*

Applicant A
Medicare number _____
Hospital (Part A) coverage starts *(MM/DD/YYYY)* _____
Medical (Part B) coverage starts *(MM/DD/YYYY)* _____

Applicant B
Medicare number _____
Hospital (Part A) coverage starts *(MM/DD/YYYY)* _____
Medical (Part B) coverage starts *(MM/DD/YYYY)* _____

Medicare Part A is hospital insurance. Medicare Part B is medical insurance. You must have both Medicare Parts A and B on your requested Medicare Supplement effective date for coverage to be issued.

C. Select a plan and effective date

Applicant A Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan High-Deductible F* ☐ Plan G ☐ Plan N

Applicant B Check plan selected: ☐ Plan A ☐ Plan F* ☐ Plan High-Deductible F* ☐ Plan G ☐ Plan N

Requested Medicare Supplement effective date (*MM/DD/YYYY*) **Applicant A** _____ **Applicant B** _____

(if no effective date is requested, we will assign the 1st day of the month following the date of this application)

*Plan F and Plan High-Deductible F are only available if you are first Medicare-eligible before 2020.

D. Are you eligible for Guaranteed Acceptance (Open Enrollment or Guaranteed Issue)?

If you lost or are losing other health insurance coverage and received a notice from your prior insurer saying you were eligible for guaranteed acceptance of a Medicare Supplement insurance policy or that you had certain rights to buy such a policy, you may be guaranteed acceptance in one or more of our Medicare Supplement plans.

The Cigna Guaranteed Acceptance Guide describes the different situations in which you may be eligible for guaranteed acceptance of a Medicare Supplement plan. It is important to note that the time period of eligibility for guaranteed acceptance may vary by situation and you must apply within this time period to be eligible for guaranteed acceptance. **Please include a copy of the notice from your prior insurer with your application.**

D.a. Guaranteed Acceptance

If you think you qualify for guaranteed acceptance, please write the number of the qualifying situation, as described in the enclosed Cigna Guaranteed Acceptance Guide, in the space below. Then attach proof of prior coverage as a separate sheet and sign and date the sheet.

I believe I qualify for guaranteed acceptance based on situation number: **Applicant A** _____ **Applicant B** _____

If applying for guaranteed acceptance under situation numbers 2, 3, 4, 5, 6, 7, 8, 13, 15, and 16 on the enclosed Cigna Guaranteed Acceptance Guide, please complete the Replacement Notice form and submit with your completed enrollment application.

D.b. Current health plan information *(MUST BE COMPLETED)*

PLEASE ANSWER ALL QUESTIONS *(mark* YES *or* NO *below with an* "X"*)*.

	Applicant A YES	Applicant A NO	Applicant B YES	Applicant B NO
Have you received a copy of the ***Guide to Health Insurance for People with Medicare*** and the **Outline of Coverage**?	☐	☐	☐	☐
To the best of your knowledge:				
1. a. Did you turn age 65 in the last six (6) months?	☐	☐	☐	☐
b. Did you enroll in Medicare Part B in the last six (6) months?	☐	☐	☐	☐
If YES, what is the effective date? *(MM/DD/YYYY)* **A**_____ **B**_____				
2. Are you covered for medical assistance through California's Medi-Cal program? (Note to Applicant: if you have "share of cost" under Medi-Cal, please answer NO to this question.)	☐	☐	☐	☐
If YES,				
a. will Medi-Cal pay your premiums for this Medicare Supplement policy?	☐	☐	☐	☐
b. do you receive any benefits from Medi-Cal OTHER THAN payments toward your Medicare Part B premium?	☐	☐	☐	☐
3. Have you had coverage from any Medicare plan other than original Medicare within the past 63 days (for example, a Medicare Advantage plan or a Medicare HMO or PPO)?	☐	☐	☐	☐
If YES,				
a. fill in your START and END dates below *(if you are still covered under this plan, leave the END date blank)*.				
A START _____ END _____				
B START _____ END _____				
b. if you are still covered under the Medicare plan, do you intend to replace your current coverage with this new Medicare Supplement policy?	☐	☐	☐	☐
c. was this your first time in this type of Medicare plan?	☐	☐	☐	☐
d. did you drop a Medicare Supplement policy to enroll in the Medicare plan?	☐	☐	☐	☐
4. a. Do you have another Medicare Supplement policy in force?	☐	☐	☐	☐
b. If so, with what company and what type plan do you have?				
A _____				
B _____				
c. If so, do you intend to replace your current Medicare Supplement policy with this policy?	☐	☐	☐	☐
If existing Medicare Supplement coverage is not to be replaced, this policy cannot be issued.				

Current health plan information *(cont'd.)*

	APPLICANT A YES	APPLICANT A NO	APPLICANT B YES	APPLICANT B NO
5. Have you had coverage under any other health insurance within the past 63 days (for example, an employer, union, or individual plan)?	☐	☐	☐	☐
6. Are you under age 65?	☐	☐	☐	☐
If YES, do you have end-stage renal disease (ESRD) or kidney disease requiring dialysis?	☐	☐	☐	☐

5. a. If so, with what company and what kind of policy?
   - **A** _____
   - **B** _____

   b. What are your dates of coverage under the other policy? *(If you are still covered under the other policy, leave the END date blank.)*
   - **A** START _____ END _____
   - **B** START _____ END _____

E. Complete medical questions (Statement of Health)

IF YOU ANSWERED SECTION D, QUESTION A, WITH ANY OF THE SITUATIONS LISTED IN THE CIGNA GUARANTEED ACCEPTANCE GUIDE, PLEASE DO NOT ANSWER THE QUESTIONS IN THIS SECTION.

It is important that you provide truthful and accurate answers to the questions in this section as your answers form the basis of our determination of your eligibility for this coverage. Failure to provide complete and accurate information, if it is determined to be material to our assessment, may result in future denial of benefits and/or rescission of this coverage.

PART A. MEDICAL QUESTIONS – If the answer to any question in Part A is YES, you are not eligible for coverage.

	APPLICANT A YES	APPLICANT A NO	APPLICANT A NOT SURE	APPLICANT B YES	APPLICANT B NO	APPLICANT B NOT SURE
1. Are you confined, scheduled for admission, or in the last two (2) years have you been confined to a nursing facility or assisted living facility?	☐	☐	☐	☐	☐	☐
2. Do you receive home health care services; or in the last two (2) years, have you received home health care services for more than three (3) separate periods of care?	☐	☐	☐	☐	☐	☐
3. Do you have a terminal illness; are you in the hospital, pending hospital admission, or have you been hospitalized more than two (2) times in the last two (2) years?	☐	☐	☐	☐	☐	☐
4. Do you receive assistance bathing, transferring, toileting, eating, dressing, or are you bedridden; have you been advised by a medical professional to use the assistance of a wheelchair, walker, or motorized mobility aid?	☐	☐	☐	☐	☐	☐
5. Do you have now or in the last two (2) years have you been treated for (including surgery) or advised by a medical professional to have treatment or surgery for any of the following:	☐	☐	☐	☐	☐	☐

- internal cancer, leukemia, malignant melanoma, Hodgkin's disease, or lymphoma?
- angioplasty, atherosclerosis or arteriosclerosis, peripheral vascular disease, carotid artery disease, coronary artery disease (CAD), angina, cardiomyopathy, stent placement, heart valve surgery, atrial fibrillation, irregular heartbeat, cardiac pacemaker, implantable or subcutaneous defibrillator, heart attack, congestive heart failure, or coronary bypass? (You should answer NO if your only treatment for these heart conditions is with maintenance medication.)
- cerebral palsy, myasthenia gravis, systemic lupus, Parkinson's disease, muscular dystrophy, multiple sclerosis, or amyotrophic lateral sclerosis (Lou Gehrig's disease)?
- Paget's disease, rheumatoid arthritis, disabling arthritis, osteoporosis with fractures, or paralysis?
- chronic kidney disease, Addison's disease, renal insufficiency, renal failure, any kidney disease requiring dialysis, pancreatitis, or any condition requiring an organ transplant?
- diabetes with hypertension requiring three (3) or more hypertension medications to control or diabetes requiring more than 50 units of insulin daily to control?
- diabetes with neuropathy, diabetes with retinopathy, or diabetes with vascular disease?
- chronic obstructive pulmonary disease (COPD), chronic obstructive lung disease (COLD), emphysema, chronic bronchitis, or other chronic lung or respiratory disorder not listed that requires the use of oxygen?
- major depression, bipolar disorder, schizophrenia, or a paranoid disorder?
- dementia, senility, Alzheimer's disease, or organic brain disorder?
- unrepaired aneurysm, hemophilia, anemia requiring repeated blood transfusions, or any other blood disorder?
- hepatitis (other than hepatitis A), alcohol or drug abuse, cirrhosis of the liver, or other liver disease?
- PSA levels greater than 6.0?
- stroke or transient ischemic attack (TIA)?

PART A. MEDICAL QUESTIONS *(cont'd.)*

	APPLICANT A			APPLICANT B		
	YES	NO	NOT SURE	YES	NO	NOT SURE
6. Do you have now or at any time have you been treated for or advised by a medical professional to have treatment for amputation caused by disease or organ transplant (other than corneas)?	☐	☐	☐	☐	☐	☐
7. Have medical tests, treatment, therapy, or surgery been advised but not performed or is any surgery anticipated? (This excludes mammograms, pap tests, colonoscopies, or PSA tests which were advised for routine screening purposes only.)	☐	☐	☐	☐	☐	☐
8. Have you ever been diagnosed with or received medical advice or treatment from a physician or an appropriately-licensed clinical professional acting within his/her scope for Acquired Immune Deficiency Syndrome (AIDS), AIDS Related Complex (ARC), or Human Immunodeficiency Virus (HIV) infection?*	☐	☐	☐	☐	☐	☐

*California law prohibits an HIV test from being required or used by health care service plans as a condition of obtaining coverage.

If you answered NO to all questions in this Section, please continue to Part B.

PART B. HEIGHT/WEIGHT, TOBACCO, AND PRESCRIPTION MEDICATIONS – The answers to questions in Part B are subject to the Company's underwriting review. Please provide complete details as requested.

9. **Applicant A** Height *(ft.-in.)* _____ Weight *(lbs.)* _____
   Applicant B Height *(ft.-in.)* _____ Weight *(lbs.)* _____

	APPLICANT A			APPLICANT B		
	YES	NO	NOT SURE	YES	NO	NOT SURE
10. Have you used tobacco within the last 12 months?*	☐	☐	☐	☐	☐	☐

*Answering this question is voluntary. Cigna Health and Life Insurance Company offers rates for non-tobacco users. In order to take advantage of the reduced rates, you must answer this question.

11. Please list any prescription medications taken or prescribed in the past two (2) years *(attach a separate sheet if needed)*.

Medication name	Dates taken	Reason for medication
Applicant A		
Applicant B		

F. Important statements for Applicant to read

- You do not need more than one Medicare Supplement policy.
- If you purchase this policy, you may want to evaluate your existing health coverage and decide if you need multiple coverages.
- You may be eligible for benefits under Medi-Cal and may not need a Medicare Supplement policy.
- If, after purchasing this policy, you become eligible for Medi-Cal, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, during your entitlement to benefits under Medi-Cal for 24 months. You must request this suspension within 90 days of becoming eligible for Medi-Cal. If you are no longer entitled to Medi-Cal, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing Medi-Cal eligibility. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- If you are eligible for and have enrolled in a Medicare Supplement policy by reason of disability and you later become covered by an employer or union-based group health plan, the benefits and premiums under your Medicare Supplement policy can be suspended, if requested, while you are covered under the employer or union-based group health plan. If you suspend your Medicare Supplement policy under these circumstances and later lose your employer or union-based group health plan, your suspended Medicare Supplement policy (or, if that is no longer available, a substantially equivalent policy) will be reinstituted if requested within 90 days of losing your employer or union-based group health plan. If the Medicare Supplement policy provided coverage for outpatient prescription drugs and you enrolled in Medicare Part D while your policy was suspended, the reinstituted policy will not have outpatient prescription drug coverage but will otherwise be substantially equivalent to your coverage before the date of the suspension.
- Counseling services may be available in your state to provide advice concerning your purchase of Medicare Supplement insurance and concerning medical assistance through the state Medi-Cal program, including benefits as a Qualified Medicare Beneficiary (QMB) and a Specified Low-income Medicare Beneficiary (SLMB). If you want to discuss buying Medicare Supplement insurance with a trained insurance counselor, call the California Department of Insurance's toll-free telephone number 1-800-927-HELP and ask how to contact your local Health Insurance Counseling and Advocacy Program (HICAP) office. HICAP is a service provided free of charge by the State of California.

As an alternative to court action, any matter in dispute between me and the Company may be subject to binding arbitration governed by the provisions of the Commercial Arbitration Rules of the American Health Lawyers Association. Any decision reached by arbitration shall be binding upon both myself and the Company and may be entered as a judgment in any court of proper jurisdiction. By signing this application, I acknowledge that I am giving up the right to a trial in court, both with and without a jury.

I hereby apply to Cigna Health and Life Insurance Company for coverage to be issued based upon the truth and completeness of the answers to the above questions, and understand and agree that: (1) no agent has the authority to waive the answer to any questions on the application; (2) no insurance will be effective until (a) a policy has been issued by the Company and (b) the initial premium has been paid; and (3) I have received the Outline of Medicare Supplement Coverage for the policy applied for and the required *Guide to Health Insurance for People with Medicare*.

CAUTION: Please review your answers to the questions on the application. It is important to the issuance of this policy that all questions are answered correctly and truthfully.

WARNING: Any person who knowingly presents a false or fraudulent claim for payment of a loss or benefit or knowingly presents false information in an application for insurance may be guilty of a crime and may be subject to fines and confinement in prison.

A recorded telephone interview may be used as part of the underwriting on your application for insurance.

Applicant A Telephone number (_____) _____ Best time to call _____

Applicant B Telephone number (_____) _____ Best time to call _____

I understand that the Medicare Supplement policy applied for will not cover loss due to Pre-Existing Condition(s) unless the expense for that loss is incurred more than six (6) months after the effective date of coverage. This provision does not apply if, as of the date of application, you had a Continuous Period of Creditable Coverage which did not expire more than 63 days ago and such coverage, while in force, lasted for at least six (6) months. If, as of the date of application, you had less than six (6) months prior Creditable Coverage, the Pre-Existing Conditions limitation will be reduced by the aggregate amount of Creditable Coverage. If this policy is replacing another Medicare Supplement policy, credit will be given for any portion of the waiting period that has been satisfied. This provision does not apply if you are applying for and are issued this policy under Guaranteed Issue status.

Applicant A Signature _____ Date _____

Applicant B Signature _____ Date _____

G. Determine your rate class

A B

☐ ☐ **Preferred** If you're eligible for Open Enrollment/Guaranteed Issue or answered NO to section E, question 10.

☐ ☐ **Standard** If you answered YES to section E, question 10.

Your final rate class is subject to underwriting review.

H. Choose your method of payment

Applicant A

Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*

☐ Direct bill *(enclose check payable to* **Cigna Health and Life Insurance Company***; do not send cash)*

☐ List bill Group name _____ Group number _____

Mode: ☐ Monthly *(bank draft or list bill only)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $_____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.

If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.89.

Applicant B

Method *(select one of the following)*:

☐ Bank draft *(complete the Electronic Funds Transfer Agreement)*

☐ Direct bill *(enclose check payable to* **Cigna Health and Life Insurance Company***; do not send cash)*

☐ List bill Group name _____ Group number _____

Mode: ☐ Monthly *(bank draft or list bill only)* ☐ Quarterly ☐ Semi-annually ☐ Annually

Premium *(see rate chart in Outline of Coverage)* $_____

If you answered YES to Section A, question 1a, and NO to 1b, multiply premium by 0.94.

If you answered YES to Section A, questions 1a and 1b, multiply premium by 0.89.

I. Agent use only

Please answer all questions:

1. I certify that I have provided the Applicant(s) with the following documents:

   a. Application packet *(phone sales only)* b. *Guide to Health Insurance for People with Medicare*

   c. Outline of Medicare Supplement Coverage d. Other _____

   I further certify that I have delivered the documents to the Applicant(s) *(check all that apply; must select at least one)*:

   Date _____ ☐ In person ☐ Mail ☐ Email ☐ Fax ☐ Other *(explain)* _____

2. Do you have knowledge or reason to believe the replacement of existing insurance may be involved?

   Applicant A: ☐ YES ☐ NO **Applicant B**: ☐ YES ☐ NO

   If YES, give name of company, reason, and termination date:

   A _____

   B _____

NOTES: Please provide additional information that may assist in processing this application (*attach a separate sheet if needed*).

_____

I certify that I have interviewed the Applicant(s), asked all of the questions as written on the application, and I have truly and accurately recorded on the application the information supplied to me by the Applicant(s).

Printed name of licensed Agent Sofia Baghaeimehr	Signature of licensed Agent	Writing number	Percentage
Printed name of 2nd licensed Agent Sofia Baghaeimehr	Signature of 2nd licensed Agent	Writing number	Percentage

CIGNA HEALTH AND LIFE INSURANCE COMPANY
PO Box 5700, Scranton, PA 18505-5700 • 866-459-4272

GUARANTEED ACCEPTANCE GUIDE

MEDICARE SUPPLEMENT PLANS

If you have recently become eligible for Medicare or lost or ended your health coverage with another plan, you may qualify for guaranteed acceptance in a Cigna Health and Life Insurance Medicare Supplement plan in certain situations. This guide will help you determine whether you qualify for guaranteed acceptance. **If you are age 64 or younger with end-stage renal disease (ESRD), you are not eligible to enroll.**

Important: Please note that this guide is only a summary and is intended to help you identify the different situations that may qualify you for guaranteed acceptance in a Cigna Health and Life Insurance Medicare Supplement plan. It does not contain all the details of each situation. It's important to remember that laws regulating guaranteed acceptance plans change frequently. Consequently, some information in this guide may no longer be accurate. Please ask your sales representative or your attorney to confirm that you qualify for guaranteed acceptance.

For more information about guaranteed acceptance, please contact your agent or your Cigna sales representative at:
Agent contact information _____
Direct | hours of operation _____

Or, if you are already a subscriber, contact Customer Service at the following number:

Customer Service	866-459-4272
TTY (for hearing impaired)	dial 711 and follow the prompts | 24 hours/day, 365 days/year
Hours of operation	Monday – Friday, 9 AM – 6 PM (Eastern time)

You may also contact the California Health Insurance Counseling and Advocacy Program (HICAP) for guidance. HICAP provides health insurance counseling for California senior citizens. Call HICAP toll-free at **800-434-0222** for a referral to your local HICAP office. HICAP is a service provided free of charge by the state of California.

How to use this guide:
1. If you believe a situation applies to you, review your plan choices and when to apply.
2. Decide which plan type you want to apply for based on plan descriptions found in Cigna's Outline of Coverage.
3. Write the corresponding situation number in the Guaranteed Acceptance section of your application. If you qualify for guaranteed acceptance, do not complete the Statement of Health or the authorization for release of medical records sections of the application. If you do not qualify for guaranteed acceptance, completion of these sections is required.
4. If you believe you qualify for guaranteed acceptance, please attach proof of prior coverage as outlined in the applicable situations below.
5. Do not return this guide with your application. Keep it as a reference along with your other important Cigna material.

During guaranteed acceptance periods which include Open Enrollment and Guaranteed Issue, we must sell you one of the required Medicare Supplement policies at the best price for your age without a waiting period or health screening.

GUARANTEED ISSUE
During Guaranteed Issue periods, we must sell you one of the required Medicare Supplement policies at the best price for your age, without a waiting period or health screening. The Guaranteed Issue period begins on the later of the date your coverage ends or the date you receive notice of your termination of coverage and ends 63 days after the coverage terminates.

__Situation 1. Reduction of Employer-Sponsored Retiree Benefits or Loss of Eligibility
You have the right to purchase certain Medicare Supplement plans if your employer-sponsored employee welfare benefit plan (including COBRA coverage) that is supplementing Medicare involuntary terminates, ceases to provide all of the supplementing benefits, the employer no longer provides you with insurance that covers all of the payment for the 20% coinsurance or you lose eligibility due to divorce or death of a spouse or family member. This federal right does not apply if the terminating health plan provided primary benefits or if you stopped paying your premium for the employee welfare benefit plan or COBRA coverage. California law is broader and provides more protection for its residents in this situation.

__Situation 2. Moving Out of Medicare Advantage (MA), PACE, Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare Select Service Area
You have the right to purchase certain Medicare Supplement plans if you have moved out of the area of your Medicare Advantage (MA), Program for All-Inclusive Care for the Elderly (PACE), Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare Select plans. You have the right to buy a Medicare Supplement policy even when MA, PACE, Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare Select plans are available in your new area.

__Situation 3. Medicare Plan Fraud, Loss of Contract, Misrepresentation, or Failure to Meet Contractual Obligations
You have the right to purchase certain Medicare Supplement plans if your Medicare Advantage (MA) plan, Medicare SELECT Plan, PACE provider, or any other health plan under contract with Medicare:

- commits fraud
- ends or loses its contract with Medicare
- misrepresents the plan you bought
- has failed to meet its contractual obligations to Medicare beneficiaries as determined by the federal government
- Involuntarily terminates your coverage

__Situation 4. Medicare Trial Period No. 1
You have the right to purchase certain Medicare Supplement plans during Medicare Trial Period No. 1: You joined a Medicare Advantage (MA) plan or Program for All-Inclusive Care for the Elderly (PACE) organization when you first became eligible for Medicare at age sixty-five (65) and you want to switch to a Medicare Supplement policy during your first twelve (12) months in the MA plan or PACE organization.
If you were previously in an MA or PACE organization, you are not eligible for this guaranteed-issue right.

__Situation 5. Medicare Trial Period No. 2
You have the right to purchase certain Medicare Supplement plans during Medicare Trial Period No. 2: You switch from a Medicare Supplement policy to a Medicare Advantage (MA) plan, Program for All-Inclusive Care for the Elderly (PACE) organization, Medicare SELECT plan, or any other health care organization contracting with Medicare for the first time since becoming eligible for Medicare and you disenroll from that plan within the first twelve (12) months. You have the option to return to your previous Medicare Supplement policy if it is still available. If it is not available, you can choose plans A, B, C, F, K, L, M, or N from any company.

__Situation 6. Medicare Advantage (MA) Plan. PACE, Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare Select Terminates Coverage in Your Area
You have the right to purchase certain Medicare Supplement plans if your Medicare Advantage (MA) PACE, Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare Select plan leaves your area. In this case, the Guaranteed Issue period begins on the later of the date you receive notice that the plan is leaving your area and ends 123 days after the coverage terminates.

_Situation 7. Medicare Advantage (MA), PACE, Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare SELECT Plan Changes

You have the right to purchase a Medicare Supplement plan if your Medicare Advantage (MA), PACE, Medicare Cost, Demonstration Project, Health Care Prepayment or Medicare Select increases your premium or co-payments by 15% or more, reduced benefits or terminated its relationship with your medical provider or the certification of the organization or plan has been terminated.

__Situation 8. Medicare Supplement plan with Medicare Part D

You have the right to purchase certain Medicare Supplement plans when enrolled under a Medicare supplement policy that covers outpatient prescription drugs and you enroll in a Medicare Part D plan during the initial enrollment period which then terminates your enrollment in the Medicare Supplement policy and you submit evidence of enrollment in Medicare Part D.

OPEN ENROLLMENT
During Open Enrollment, you have the right to receive one of the required Medicare Supplement policies at the best price for your age, without medical underwriting (health screening).

__Situation 9. If You Are Age 65 or Over
If you are age sixty-five (65) or over and eligible for Medicare, you have a six (6) month period during which you can purchase any Medicare Supplement policy at the lowest price for your age, even if you have or recently had health problems. Your six (6) month open enrollment period starts the date your Medicare Part B coverage becomes effective.

__Situation 10. If You Are Younger than Age 65
If you are younger than age sixty-five (65) and have Medicare because of a disability (except for End-Stage Renal Disease), you have open enrollment rights for six (6) months after the effective date of your Medicare Part B coverage. If you are notified retroactively of your eligibility for Medicare, your open enrollment period begins from the date of the notice you receive from Social Security.

__Situation 11. Termination of Employment or Retirement Plan
You have the right to purchase a Medicare Supplement policy for six (6) months if you, your spouse's, or a family member's current employment or retirement plan coverage terminates or you lose your eligibility due to divorce or death of a spouse or family member. The six (6) month period to apply for a Medicare Supplement policy starts on the date you receive notice that your health benefits will end. If you do not receive advance notice, the six (6) month period starts the date the benefits end or the date of your first denied claim. This right applies whether your group health benefits were primary or secondary to Medicare. You are also entitled to this protection when you have used all the COBRA benefits to which you are entitled unless you stop paying COBRA premiums before you use all your benefits.

__Situation 12. Loss of Medi-Cal Benefits
You have the right to purchase a Medicare Supplement policy for six (6) months when you lose your eligibility for full benefits because of an increase in your income or assets.

__Situation 13. Moving Out of the Medicare Supplement Plan's Service Area
You have the right to purchase a Medicare Supplement policy for six (6) months if you move out of the area served by your Medicare Supplement plan. For example, if you bought a plan while living in another state that will not cover you in your current state, you have six (6) months to replace that plan.

__Situation 14. Loss of Military Health Coverage
You have the right to purchase a Medicare Supplement policy for six (6) months if your health care coverage ends because:

- a military base closes
- a military base no longer offers health care services
- you move away from a military base
- you lose access to health care services at a military base

__Situation 15. Annual 60-Day Period Starting on Your Birthday
You have the right to purchase certain Medicare Supplement plans each year for the sixty (60)-day period starting on your birthday. You must have a current Medicare Supplement plan to exercise that right. You can choose a plan from any company, but you may be limited to one that has the same or fewer benefits than your current plan. For example, if you already have Plan C, you may want to switch to another Plan C but may not be able to switch to Plan G.

__Situation 16. Medicare Advantage Plan Coverage Terminated
You have the right to an additional sixty (60) day open enrollment period to be added onto or after any open enrollment period authorized by federal law or regulation for any Medicare Supplement plan available on a guaranteed issue basis if your Medicare Advantage plan was terminated.

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA HEALTH AND LIFE INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

☐ **Joint Account** – ***only one form is needed for Joint Account*** ☐ **Applicant A only** ☐ **Applicant B only**		
Proposed Insured Name		**Policy Number** *(if available)*
Financial Institution Name and Telephone Number		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date** *(1st - 28th)*

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

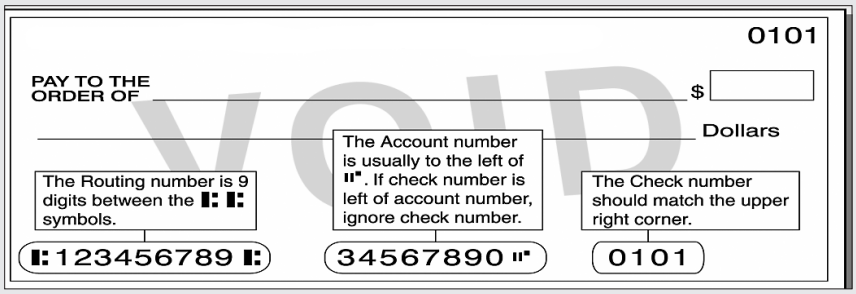
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Cigna Health and Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Cigna Health and Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Cigna Health and Life Insurance Company mistakenly deposits funds into my account, I authorize Cigna Health and Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR CIGNA HEALTH AND LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Cigna Health and Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Cigna Health and Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Cigna Health and Life Insurance Company upon 30 days written notice.

Name of Payor *(if other than Insured)* **Payor's Address**

Print name of Depositor *(as it appears on account)* **Signature of Depositor** **Date**

PRE-AUTHORIZATION AGREEMENT FOR ELECTRONIC FUNDS TRANSFER

CIGNA HEALTH AND LIFE INSURANCE COMPANY • PO BOX 5725, SCRANTON, PA 18505-5725

☐ **Joint Account** – ***only one form is needed for Joint Account*** ☐ **Applicant A only** ☐ **Applicant B only**		
Proposed Insured Name		**Policy Number** *(if available)*
Financial Institution Name and Telephone Number		
9-digit Routing Number	**Account Number**	**Requested Withdrawal Date** *(1st - 28th)*

Withdraw Payment: ☐ Monthly ☐ Quarterly ☐ Semi-annually ☐ Annually

Type of Account: ☐ Personal Checking Account ☐ Personal Savings Account ☐ Corporate/Business Checking

Name of Employer Group _____

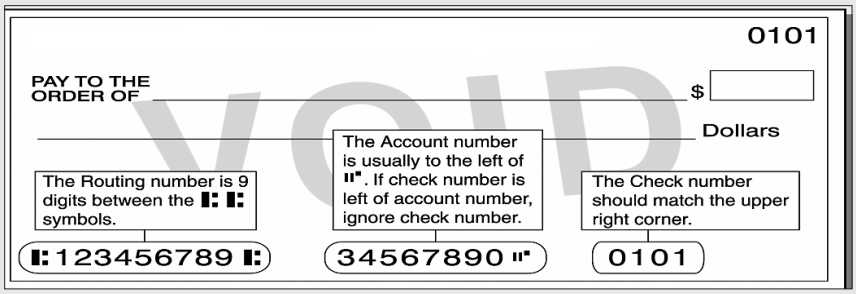
Purpose for submitting this Authorization (check appropriate box(es)):

☐ New authorization ☐ Change in checking/savings account

☐ Change in financial institution ☐ Change in existing coverage

For checking account:
Refer to the sections on the sample check.

For savings account:
Please verify with your bank the account and routing number of your savings account.



APPLICANT A OR APPLICANT B INFORMATION FOR FINANCIAL INSTITUTIONS: As a convenience to me, I hereby request and authorize you to pay and charge to my account, drafts drawn on my account by and payable to Cigna Health and Life Insurance Company provided there are sufficient funds in said account to pay the same on presentation. Such drafts will bear my printed name. I also authorize Cigna Health and Life Insurance Company and any financial institution it uses to initiate credit entries to my account or to provide refund of premium or association fees (if applicable). I authorize you to accept and to credit these entries to my account. In the event Cigna Health and Life Insurance Company mistakenly deposits funds into my account, I authorize Cigna Health and Life Insurance to debit my account for an amount not to exceed the original amount of credit. This authorization shall remain in effect until revoked by me in writing, and until you actually receive such notice. I agree that you shall be fully protected in honoring any such draft. I agree that your rights in respect to any such draft shall be the same as if it were a check signed personally by me. I further agree that if any such draft is dishonored, whether intentionally or inadvertently, you shall be under no liability whatsoever even though such dishonor results in the forfeiture of insurance.

APPLICANT A OR APPLICANT B INFORMATION FOR CIGNA HEALTH AND LIFE INSURANCE COMPANY: It is understood that the initial draft will occur when the policy is issued. All subsequent drafts will be drawn on or about the requested date each month. The presentation of such drafts to the above Financial Institution shall constitute notice of premiums being due upon the contract and association fees (if applicable), and no other notice of premiums or association fees (if applicable) due will be given. No premium or association fee (if applicable) shall be deemed to have been paid unless and until actual payment of the draft drawn for such premium or association fee (if applicable) payment has been received by Cigna Health and Life Insurance Company. The cancelled draft will constitute receipt of premium or association fee (if applicable) payment. The privilege of paying premiums and association fees (if applicable) under this Plan may be revoked by Cigna Health and Life Insurance Company if any draft is not paid upon presentation. The payment of premiums and association fees (if applicable) under this Plan may be terminated by the Contract Owner, Financial Institution Depositor if other than Contract Owner, or by Cigna Health and Life Insurance Company upon 30 days written notice.

Name of Payor *(if other than Insured)* **Payor's Address**

Print name of Depositor *(as it appears on account)* **Signature of Depositor** **Date**

AUTHORIZATION FORM FOR DISCLOSURE OF AN APPLICANT'S PROTECTED HEALTH INFORMATION

I hereby authorize the disclosure of protected health information about me as described below.

1. The Company, as used in this authorization, shall mean American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates as described below.
2. I authorize any licensed physician, medical practitioner, hospital, clinic, Pharmacy Benefit Manager, or other medical or medically-related facility, the U. S. Veterans Administration and Selective Service System, insurance company, MIB, Inc., or any other organization, institution, or person that has any records or information available as to the diagnosis, treatment, and prognosis with respect to any physical or mental condition and/or treatment relating to me or my family to disclose to the Company's underwriting, new business, claims, sales agents, and premium accounting representatives any such records or information. However, MIB, Inc., information will only be shared with the Company's underwriting staff and Medical Director.
3. I authorize the Company to make a brief report of my protected health information to MIB, Inc.
4. The protected health information described above will be disclosed to the Company to determine my or my family's eligibility to obtain coverage under the policy for which I/we have applied, and to determine the rates and terms which apply to the policy.
5. This medical or health information includes information on the diagnosis and treatment of mental illness, alcohol, and drug use. This also includes information on the diagnosis, treatment, and testing results related to HIV, AIDS, and sexually-transmitted diseases unless otherwise restricted by state law.
6. I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken by the Company in reliance on this authorization, by sending a written revocation to the Company's Privacy Office at PO Box 5700, Scranton, PA 18505-5700.
7. I understand that the information which will be provided under this authorization is necessary for the Company to determine my eligibility for coverage under the policy and that the Company will condition its approval and issuance of the policy on my providing this authorization, and my application may be denied if I refuse to provide this authorization.
8. I understand that if the person or entity that receives my protected health information is not a health care provider or health plan covered by the federal privacy regulations, the information may be re-disclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
9. I understand that a photocopy, facsimile copy, or other electronic copy of this authorization shall be considered as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this authorization upon request. This authorization will expire twenty-four (24) months from the date it is signed.
10. If you are the representative of an Applicant, describe the scope of your authority to act on the Applicant's behalf:

_____

Applicant A Name

Name of Applicant A Personal Representative, if applicable

Applicant A Social Security Number

Relationship of Personal Representative to Applicant A

Applicant A Signature **Date**

Signature of Personal Representative **Date**

Applicant B Name

Name of Applicant B Personal Representative, if applicable

Applicant B Social Security Number

Relationship of Personal Representative to Applicant B

Applicant B Signature **Date**

Signature of Personal Representative **Date**

Signature of Company's Agent **Date**

A signed copy of this form will be provided with the policy if issued and any other time upon request.

AUTHORIZATION FORM FOR DISCLOSURE OF A CONSUMER'S PROTECTED HEALTH INFORMATION FOR MARKETING PURPOSES ("Authorization")

1. I hereby authorize the use and disclosure of all my health information, including but not limited to my personal and medical information contained in the Company's records ("Protected Health Information") to American Retirement Life Insurance Company, Loyal American Life Insurance Company®, Cigna Health and Life Insurance Company, Cigna National Health Insurance Company, and their affiliates ("Company") as described below.
2. I authorize the Company to use the Protected Health Information contained in the Company's records, including its underwriting and claim records, to help determine whether I might be interested in or can benefit from other non-health-related insurance products offered by the Company.
3. I understand that the Company will disclose the Protected Health Information to its underwriting staff, new business staff, sales agents, or marketing management for the purpose of marketing non-health-related products to me.
4. I understand that I may revoke this Authorization at any time, except to the extent that action has been taken by the Company in reliance on this Authorization, by sending a written revocation to the Company's Privacy Steward at PO Box 5700, Scranton, PA 18505-5700.
5. I understand that the Protected Health Information which the Company will use and disclose under this Authorization is not necessary for the Company to determine my eligibility for coverage under the policy and that the Company will not condition its approval and issuance of the policy on my providing this Authorization.
6. I understand that if the person or entity that receives my Protected Health Information is not a health care provider or health plan covered by the federal privacy regulations, the information may be redisclosed by such person or entity and will likely no longer be protected by the federal privacy regulations.
7. I understand that a photocopy, facsimile copy, or other electronic copy of this Authorization is as effective and valid as the original. I also understand that I or my personal representative am entitled to receive a copy of this Authorization. This Authorization will remain in effect for two (2) years from the day my policy(ies) is terminated or the day I revoke my permission.
8. By providing my telephone number(s) on the attached application for insurance, I consent to receive calls, texts, or autodialed or prerecorded telemarketing messages from Cigna and its affiliates.

If you are the representative of a Consumer, describe the scope of your authority to act on the Consumer's behalf:

_____

Applicant A Name

Applicant A Signature **Date**

Name of Applicant A Personal Representative, if applicable

Relationship of Personal Representative to Applicant A

Signature of Personal Representative **Date**

Applicant B Name

Applicant B Signature **Date**

Name of Applicant B Personal Representative, if applicable

Relationship of Personal Representative to Applicant B

Signature of Company's Agent **Date**

Signature of Personal Representative **Date**

A signed copy of this form will be provided to you.

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna Health and Life Insurance Company (CHLIC) with the application.

A copy of this form must also be left with the Applicant.

NOTICE TO APPLICANT REGARDING REPLACEMENT OF MEDICARE SUPPLEMENT INSURANCE OR MEDICARE ADVANTAGE

CIGNA HEALTH AND LIFE INSURANCE COMPANY
PO Box 5725, Scranton, PA 18505 • 866-459-4272

SAVE THIS NOTICE! IT MAY BE IMPORTANT TO YOU IN THE FUTURE.

According to your application, you intend to terminate existing Medicare Supplement or Medicare Advantage insurance and replace it with a policy to be issued by Cigna Health and Life Insurance Company. Your new policy will provide thirty (30) days within which you may decide without cost whether you desire to keep the policy.

You should review this new coverage carefully. Compare it with all accident and sickness coverage you now have. If, after due consideration, you find that the purchase of this Medicare Supplement coverage is a wise decision, you should terminate your present Medicare Supplement or Medicare Advantage coverage. You should evaluate the need for other accident and sickness coverage you have that may duplicate this policy.

STATEMENT TO APPLICANT BY ISSUER, AGENT, OR BROKER

I have reviewed your current medical or health insurance coverage. To the best of my knowledge, this Medicare Supplement policy will not duplicate your existing Medicare Supplement or, if applicable, Medicare Advantage coverage because you intend to terminate your existing Medicare Supplement coverage or leave your Medicare Advantage plan. The replacement coverage is being purchased for the following reason (check one):

Applicant A

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

Applicant B

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

Sofia Baghaeimehr

_____ _____

Agent/Broker printed name and signature **Date**

_____ _____

Applicant A signature **Date**

_____ _____

Applicant B signature **Date**

Instructions to Agent: This form is provided for the purpose of compliance with regulations regarding the replacement of Medicare Supplement insurance. When the replacement question on the application is answered "Yes," this form must be dated, signed by the Applicant and by the Agent, and submitted to the Cigna Health and Life Insurance Company (CHLIC) with the application.

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- ☐ fewer benefits and lower premiums
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- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

Applicant B

- ☐ additional benefits
- ☐ no change in benefits, but lower premiums
- ☐ fewer benefits and lower premiums
- ☐ my plan has outpatient prescription drug coverage and I am enrolling in Part D
- ☐ disenrollment from a Medicare Advantage plan; please explain reason for disenrollment
- ☐ other (please specify) _____

_____

If you still wish to terminate your present policy and replace it with new coverage, be certain to truthfully and completely answer all questions on the application concerning your medical and health history. Failure to include all material medical information on an application may provide a basis for the Company to deny any future claims and to refund your premiums as though your policy had never been in force. After the application has been completed and before you sign it, review it carefully to be certain that all information has been properly recorded.

DO NOT CANCEL YOUR PRESENT POLICY UNTIL YOU HAVE RECEIVED YOUR NEW POLICY AND ARE SURE YOU WANT TO KEEP IT.

Sofia Baghaeimehr

_____ _____

Agent/Broker printed name and signature **Date**

_____ _____

Applicant A signature **Date**

_____ _____

Applicant B signature **Date**

DISCRIMINATION IS AGAINST THE LAW

Medicare Supplement coverage

Cigna complies with applicable Federal civil rights laws and does not discriminate on the basis of race, color, national origin, age, disability, or sex. Cigna does not exclude people or treat them differently because of race, color, national origin, age, disability, or sex.

Cigna:

- Provides free aids and services to people with disabilities to communicate effectively with us, such as:
  - Qualified sign language interpreters
  - Written information in other formats (large print, audio, accessible electronic formats, other formats)
- Provides free language services to people whose primary language is not English, such as:
  - Qualified interpreters
  - Information written in other languages

If you need these services, contact customer service at the toll-free number shown on your ID card or call 1.866.459.4272 (TTY: Dial 711), and ask a Customer Service Associate for assistance.

If you believe that Cigna has failed to provide these services or discriminated in another way on the basis of race, color, national origin, age, disability, or sex, you can file a grievance by sending an email to ACAGrievance@Cigna.com or by writing to the following address:

Cigna
Nondiscrimination Complaint Coordinator
PO Box 188016
Chattanooga, TN 37422

If you need assistance filing a written grievance, please call 1.866.459.4272 (TTY: Dial 711), or send an email to ACAGrievance@Cigna.com. You can also file a civil rights complaint with the U.S. Department of Health and Human Services, Office for Civil Rights electronically through the Office for Civil Rights Complaint Portal, available at https://ocrportal.hhs.gov/ocr/portal/lobby.jsf, or by mail or phone at:

U.S. Department of Health and Human Services
200 Independence Avenue, SW
Room 509F, HHH Building
Washington, DC 20201
1.800.868.1019, 800.537.7697 (TDD)
Complaint forms are available at
http://www.hhs.gov/ocr/office/file/index.html.

Proficiency of Language Assistance Services

English – ATTENTION: Language assistance services, free of charge, are available to you. For current Cigna customers, call the number on the back of your ID card. Otherwise, call 1.866.459.4272 (TTY: Dial 711).

Spanish – ATENCIÓN: Hay servicios de asistencia de idiomas, sin cargo, a su disposición. Si es un cliente actual de Cigna, llame al número que figura en el reverso de su tarjeta de identificación. Si no lo es, llame al 1.866.459.4272 (los usuarios de TTY deben llamar al 711).

Chinese – 注意：我們可為您免費提供語言協助服務。對於 Cigna 的現有客戶，請致電您的 ID 卡背面的號碼。其他客戶請致電 1.866.459.4272（聽障專線：請撥 711）。

Vietnamese – XIN LƯU Ý: Quý vị được cấp dịch vụ trợ giúp về ngôn ngữ miễn phí. Dành cho khách hàng hiện tại của Cigna, vui lòng gọi số ở mặt sau thẻ Hội viên. Các trường hợp khác xin gọi số 1.866.459.4272 (TTY: Quay số 711).

Korean – 주의: 한국어를 사용하시는 경우, 언어 지원 서비스를 무료로 이용하실 수 있습니다. 현재 Cigna 가입자님들께서는 ID 카드 뒷면에 있는 전화번호로 연락해주십시오. 기타 다른 경우에는 1.866.459.4272 (TTY: 다이얼 711)번으로 전화해주십시오.

Tagalog – PAUNAWA: Makakakuha ka ng mga serbisyo sa tulong sa wika nang libre. Para sa mga kasalukuyang customer ng Cigna, tawagan ang numero sa likuran ng iyong ID card. O kaya, tumawag sa 1.866.459.4272 (TTY: I-dial ang 711).

Russian – ВНИМАНИЕ: вам могут предоставить бесплатные услуги перевода. Если вы уже участвуете в плане Cigna, позвоните по номеру, указанному на обратной стороне вашей идентификационной карточки участника плана. Если вы не являетесь участником одного из наших планов, позвоните по номеру 1.866.459.4272 (TTY: 711).

Arabic – برجاء الانتباه خدمات الترجمة المجانية متاحة لكم. لعملاء Cigna الحاليين برجاء الاتصال بالرقم المدون علي ظهر بطاقتكم الشخصية. او اتصل ب 1.866.459.4272 (TTY: اتصل ب 711).

French Creole – ATANSYON: Gen sèvis èd nan lang ki disponib gratis pou ou. Pou kliyan Cigna yo, rele nimewo ki dèyè kat ID ou. Sinon, rele nimewo 1.866.459.4272 (TTY: Rele 711).

French – ATTENTION: Des services d'aide linguistique vous sont proposés gratuitement. Si vous êtes un client actuel de Cigna, veuillez appeler le numéro indiqué au verso de votre carte d'identité. Sinon, veuillez appeler le numéro 1.866.459.4272 (ATS : composez le numéro 711).

Portuguese – ATENÇÃO: Tem ao seu dispor serviços de assistência linguística, totalmente gratuitos. Para clientes Cigna atuais, ligue para o número que se encontra no verso do seu cartão de identificação. Caso contrário, ligue para 1.866.459.4272 (Dispositivos TTY: marque 711).

Polish – UWAGA: w celu skorzystania z dostępnej, bezpłatnej pomocy językowej, obecni klienci firmy Cigna mogą dzwonić pod numer podany na odwrocie karty identyfikacyjnej. Wszystkie inne osoby prosimy o skorzystanie z numeru 1.866.459.4272 (TTY: wybierz 711).

Japanese – 注意事項：日本語を話される場合、無料の言語支援サービスをご利用いただけます。現在のCignaのお客様は、IDカード裏面の電話番号まで、お電話にてご連絡ください。その他の方は、1.866.459.4272（TTY: 711）まで、お電話にてご連絡ください。

Italian – ATTENZIONE: Sono disponibili servizi di assistenza linguistica gratuiti. Per i clienti Cigna attuali, chiamare il numero sul retro della tessera di identificazione. In caso contrario, chiamare il numero 1.866.459.4272 (utenti TTY: chiamare il numero 711).

German – ACHTUNG: Die Leistungen der Sprachunterstützung stehen Ihnen kostenlos zur Verfügung. Wenn Sie gegenwärtiger Cigna-Kunde sind, rufen Sie bitte die Nummer auf der Rückseite Ihrer Krankenversicherungskarte an. Andernfalls rufen Sie 1.866.459.4272 an (TTY: Wählen Sie 711).

Persian (Farsi) – توجه: خدمات کمک زبانی، به صورت رایگان به شما ارائه می‌شود. برای مشتریان فعلی Cigna، لطفاً با شماره‌ای که در پشت کارت شناسایی شماست تماس بگیرید. در غیر اینصورت با شماره 1.866.459.4272 تماس بگیرید (شماره تلفن ویژه ناشنوایان: شماره 711 را شماره‌گیری کنید).